

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02240					02236				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)				
a. COUNTY Harford MARYLAND					a. STATE Pa b. COUNTY Oxford				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Three-de-grace					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mottling, Maryland				
c. LENGTH OF STAY IN 1b 18 days					d. STREET ADDRESS				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Carlton M. Abernathy					4. DATE OF DEATH February 17 1967				
5. SEX Male					6. COLOR OR RACE White				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH Oct 1, 1891				
9. AGE (In years last birthday) 75 yrs.					10. IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY				
11. BIRTHPLACE (County & State, or foreign country) Fairville, Maryland					12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME John William Abernathy					14. MOTHER'S MAIDEN NAME Mary Sellers				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 179-12-894				
17. INFORMANT					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bacterial Pneumonia					18 days				
260X DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Scurvy, inanition, chronic Brain syndrome.					Unknown				
DUE TO (c) Diabetes, Scurvy of lip, Foot, A.S.H.D									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 1-31, 1967, to 2-17, 1967, that (I) (we) last saw the deceased alive on 2-17, 1967, and that death occurred at 4:41 AM, from the causes and on the date stated above.									
22a. SIGNATURE					22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) MAHER W ISHAK, M.D.					22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial					23b. DATE THEREOF Feb. 21, 1967				
23c. NAME OF CEMETERY OR CREMATORY Oxford Cem.					23d. LOCATION (City, town or county) (State) Oxford, Chester Co Pa				
24. FUNERAL DIRECTOR See A. Enten + Son, Fairville, Md.					25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE				
DATE FEB 23 1967					Charles Judge				

05338

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Threats to the water supply
of the city of New York

1907
Bureau of Sanitation
New York City
Bureau of Sanitation
New York City

CHANDLER
HARRIS W. 1907

FOR STATE
HEALTH DEPT.

02241

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02237

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fallston</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fallston</u>	
c. LENGTH OF STAY IN 1b <u>17 years</u>		d. STREET ADDRESS <u>RD 2 Box 339</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 339 RD 2</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joseph Earl Barr</u>		4. DATE OF DEATH Month <u>February</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-1-21</u>
9. AGE (In years lost birthday) <u>46</u> yrs.		10. IF UNDER 1 YEAR Months <u>46</u> Days <u>46</u> Hours <u>46</u> Min.	11. IF UNDER 24 HRS. Hours <u>46</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boiler fireman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Industrial Bldg.</u>	
11. BIRTHPLACE (State or foreign country) <u>Glade Spring, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Grant E. Barr</u>		14. MOTHER'S MAIDEN NAME <u>Pearl Brewer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW 2</u>		16. SOCIAL SECURITY NO. <u>225-18-8313</u>	
17. INFORMANT <u>Opal M. Barr</u>		Address <u>RD #2 Box 339</u> <u>Fallston, Md. 21047</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>976X</u> IMMEDIATE CAUSE (a) <u>GSW L Chest</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>2-1</u> 19 <u>67</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>
20f. (City or town) <u>Fallston Md.</u>		(County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Be A Ir</u> and	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>2-1-67</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/4/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Long Green Church Of The Brethren Long Green, Maryland</u>	23d. LOCATION (City or Town) _____ (County) _____ (State) _____
24. FUNERAL DIRECTOR <u>Charles E. Kurtz</u>		25a. REC'D BY REGISTRAR <u>1967</u>	
Jarrettsville, Md.		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner. One along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE
HEALTH DEPT.

02242

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02238

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Bel Air		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S.#1		d. STREET ADDRESS 309 Academy Avenue	
3. NAME OF DECEASED (Type or print) First Leslie Middle Martin Last Beaver		4. DATE OF DEATH Month February Day 26 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 25, 1920
9. AGE (In years last birthday) 47		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator		10b. KIND OF BUSINESS OR INDUSTRY Gas Station	
11. BIRTHPLACE (State or foreign country) Oklahoma		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Van Beaver		14. MOTHER'S MAIDEN NAME Orpha Green	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 446-01-2178	
17. INFORMANT (Wife) 833-6185		Address 309 Academy Ave. Reisterstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to C.O. DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 12 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Went to sleep with car motor running in garage	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 2-25 19 67 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Service Sta. Garage		20f. (City or town) (County) (State) Bel Air Harford Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Gerald C. Palmer M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> 2-26-67	
EXAMINER'S NAME (Type) Gerald C. Palmer, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22. DATE SIGNED Feb. 26, 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF March 3, 67	
23c. NAME OF CEMETERY OR CREMATORY Hominy Cemetery		23d. LOCATION (City or Town) (County) (State) Osage Co. Oklahoma	
24. FUNERAL DIRECTOR J. F. Eline & Sons		ADDRESS Reisterstown, Md.	
25a. REC'D BY REGISTRAR DATE MAR 1 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02243						02239					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence, before admission)					
a. COUNTY			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			a. STATE			b. COUNTY		
Harford			Harford			Md			Harford		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			d. IS RESIDENCE ON A FARM?		
Harford-de-Grace			6 days			Aberdeen			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS					
Harford Memorial Hospital						309 S. Park St Apt 6 Aberdeen					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH		Month		Day Year	
Eunice Hough Brown						2 8 1967					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
Female		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		31 Oct. 1908		58 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Historian. A.P.S.				Dept. of Army		Washington					
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
Bernice Nelson Hough						Ida Taylor					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT Address					
No				554-16-6537		Alvin E. Brown, Cupertino, Calif.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis and A.S.C.V.D.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
Hour a.m. p.m. 19				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		Feb. 2nd 1967		Feb. 8th 1967			
21. I certify that (I) (this hospital) attended the deceased from Feb. 2nd 1967 to Feb. 8th 1967, that (I) (we) last saw the deceased alive on Feb. 8th 1967 and that death occurred at 5 PM, from the causes and on the date stated above.											
22a. SIGNATURE						22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)			
Edward C. Loo, M.D.						2/8/67		Edward C. Loo, M.D.			
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS		22e. REC'D BY REGISTRAR			
Edward C. Loo, M.D.						Harford-de-Grace, Md.		22f. REGISTRAR'S SIGNATURE			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)		(State)	
Burial				14 Feb. 67		Arlington National Cemetery, Ft Meyer, Va.		Aberdeen, Md.			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Tarring Funeral Home						DATE FEB 14 1967		Charles Judge			

2280

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02244 CERTIFICATE OF DEATH 02241											
1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>					
c. LENGTH OF STAY IN 1b <u>10.0</u>						d. STREET ADDRESS <u>724 Water ST</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harford Memorial Hospital</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>MYRTLE DESMA CUFFLEY</u>						4. DATE OF DEATH Month <u>2</u> Day <u>18</u> Year <u>1967</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAR. 7, 1905</u>		9. AGE (In years last birthday) <u>61</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME RETIRED</u>				11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>THOMAS SAMPSON</u>						14. MOTHER'S MAIDEN NAME <u>ANNIE SINGLETON</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>						16. SOCIAL SECURITY NO. <u>217-09-1374</u>		17. INFORMANT <u>FLORENCE V. CLARK</u> Address <u>724 WATER ST. HARREDEGRACE MD 21078</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>2/18/67</u> , 19 <u>66</u> to <u>2/18/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2/18/67</u> , 19 <u>67</u> , and that death occurred at <u>7:00 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>William H. Williams</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>2/18/67</u>		
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>FEB. 21, 1967</u>			23c. NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL CEM.</u>			23d. LOCATION (City, town or county) (State) <u>HARREDEGRACE MD</u>		
24. FUNERAL DIRECTOR <u>R. Madison Mitchell</u> ADDRESS <u>Harre-de-Grace, Md. 21078</u>						25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>FEB 23 1967</u>			25b. REGISTRAR'S SIGNATURE		

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CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE MD. b. COUNTY HARFORD	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL HAVRE DE GRACE		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL HAVRE DE GRACE	
c. LENGTH OF STAY IN 1b 2 1/2 yrs		d. STREET ADDRESS MARYLAND AVE BOX 382	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MARYLAND AVE. BOX 382		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MATTIE BROOKS CRAWFORD		4. DATE OF DEATH Month Day Year FEB. 13, 1967 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 18, 1886
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (County & State, or foreign country) PA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS NODEN BROOKS		14. MOTHER'S MAIDEN NAME SALLIE McBRIDE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. 217-52-8015	
17. INFORMANT T. BROOKS CRAWFORD		Address 618 PARKMAN ST. HAVRE DE GRACE MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Bladder 1810 DUE TO Conditions, if any, which gave rise to immediate cause (b) (carcinomatosis) (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Nov. 21, 1956 , to FEB. 13, 1967 , that (I) (we) last saw the deceased alive on 2/12, 1967 and that death occurred at MD. from the causes and on the date stated above.			
22a. SIGNATURE AL. LEWIS, MD.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) AL. LEWIS, MD.		22d. ADDRESS Havre de Grace, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF FEB. 16, 1967	23c. NAME OF CEMETERY OR CREMATORY ANGEL HILL CEM.	23d. LOCATION (City, town or county) (State) HAVRE DE GRACE, MD
24. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell		25a. REC'D BY REGISTRAR FEB 17 1967	
ADDRESS Havre de Grace, Md.		25b. REGISTRAR'S SIGNATURE J. Charles Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03340

03340

Enclosure of 1/10/1941
(Carson's collection)

1/10/1941
1/10/1941
1/10/1941

VR A15 (4)
2DM 5-63

MEDICAL CERTIFICATION

03588

RECEIVED

03588

FEB 28 1967

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02247

CERTIFICATE OF DEATH

02243

1. PLACE OF DEATH a. COUNTY Harford b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Norrisville c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Norrisville d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Laura Catherine Duncan First Middle Last		4. DATE OF DEATH Feb. 26 Month Day Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/13/1881 9. AGE (In years last birthday) yrs. 85
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harvey Dunlap		14. MOTHER'S MAIDEN NAME Elizabeth Wise	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 178-22-9655	
17. INFORMANT W.H. Duncan		Address Stewartstown RD#1, Pa.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 331X IMMEDIATE CAUSE (a) Cerebral hemorrhage, hemiplegia DUE TO (b) (right side) Chr. myo carditis, fibrillation DUE TO (c) & infirmities of old age. CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 67	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Feb. 10, 1967 , to Feb. 26, 1967 , that (I) (we) last saw the deceased alive on Feb. 25, 1967 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE Norman H. Gemmill		22b. DATE SIGNED Feb. 26, 1967	
22c. PHYSICIAN'S NAME (Type) Norman H. Gemmill		22d. ADDRESS Stewartstown, Pa.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2/28/67	23c. NAME OF CEMETERY OR CREMATORY Norrisville Cem.	23d. LOCATION (City or Town) (County) (State) Norrisville, Harford Co.
24. FUNERAL DIRECTOR Bennett W. Osburn		25. REC'D BY REGISTRAR Charles Judge	
ADDRESS Stewartstown, Pa.		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE FEB 28 1967		DATE FEB 28 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05518

RECEIVED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Harford b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fallston RD c. LENGTH OF STAY IN 1b 6 mo. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Box 2 Route 2		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fallston d. STREET ADDRESS Box 2 Route 2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George Dewey Edmondson First Middle Last 4. DATE OF DEATH Feb. 18 19 67 Month Day Year		5. SEX M 6. COLOR OR RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH July 20, 1898 9. AGE (In years last birthday) 68 yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) Carroll County 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Alfred Edmondson 14. MOTHER'S MAIDEN NAME Josephine Brothers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) -- (If yes give war or dates of service) -- 16. SOCIAL SECURITY NO. 220-09-5840 17. INFORMANT Mrs. William Ball Address same		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Reticulum Cell Sarcoma 2 200.0 DUE TO generalized Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from Oct. , 19 66 , to Feb , 19 67 , that (I) (we) last saw the deceased alive on Feb 16 19 67 , and that death occurred at 5:30 PM , from the causes and on the date stated above. 22a. SIGNATURE William A. Tyson 22c. PHYSICIAN'S NAME (Type) William A. Tyson 22b. DATE SIGNED 2-18-67 ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Kingsville Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial 23b. DATE THEREOF 2/21/67 23c. NAME OF CEMETERY OR CREMATORY Westminster Cemetery 23d. LOCATION (City, town or county) (State) Westminster, Maryland		24. FUNERAL DIRECTOR Robert Kyle Britts Jr. ADDRESS Westminster, Md. 25a. REC'D BY REGISTRAR FEB 21 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02249

CERTIFICATE OF DEATH

02245

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE de GRACE</u>		c. LENGTH OF STAY IN lb <u>10 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARFORD Memorial Hospital</u>				d. STREET ADDRESS <u>2304 Mountain Rd.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Emma</u> <u>Barbara</u> <u>Emmord</u>				4. DATE OF DEATH Month Day Year <u>Feb.</u> <u>26</u> <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 17, 1893</u>		9. AGE (In years last birthday) yrs. <u>74</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bindery Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt - Ret.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles A. Hoffman</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Pailka</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-20-7039</u>		17. INFORMANT Address <u>George T. Moyer, Perryman, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute renal failure</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASCVD & Hypotension</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Metastatic Ca of Colon & splenic flexure</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-10</u> , 19 <u>67</u> , to <u>2-26</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>Feb. 26</u> 19 <u>67</u> , and that death occurred at <u>4:35 PM</u> , from causes on and on the date stated above.							
22a. SIGNATURE <u>Charles J. Groland MD</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/26/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>A.W. Grigolt</u>				22d. ADDRESS <u>Havre de Grace, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Mar. 1, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Trinity Lutheran Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Joppa Harford Md</u>	
24. FUNERAL DIRECTOR <u>Howa rd K. McComas & Son, Abingdon, Md. 21009</u>				25a. REC'D BY REGISTRAR <u>DATE FEB 28 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

03330

CERTIFICATE OF DEATH

03330

FEB 28 1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02250						02246					
1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL WHITE HALL				c. LENGTH OF STAY IN 1b 12 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL WHITE HALL				d. STREET ADDRESS NORRISVILLE ROAD RD #1 BOX 252	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) NORRISVILLE ROAD						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) LULU MAY HAMMOND			First Middle Last			4. DATE OF DEATH FEB. 14 1967			Month Day Year		
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 12 1891		9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HORSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (County & State, or foreign country) MARSHALL Co. W. Va.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOHN NICHOLAS UTTER						14. MOTHER'S MAIDEN NAME MINNIE EMMA WASERMIER					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				16. SOCIAL SECURITY NO. 215-50-230 SRS.		17. INFORMANT RD1 Address BOX 252 MRS. JOSEPH CREECH WHITE HALL, MD 21161					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA, cerebral sclerosis 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) chronic arterio sclerosis + (a), stating the underlying cause last. DUE TO (c) infarction of old age											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19			20d. INJURY OCCURRED While Not While at work at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from May 1964 to 2-14 , 19 67 that (I) (we) last saw the deceased alive on 2-7 , 19 67 , and that death occurred at 1 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Norman H. Gemmill						22b. DATE SIGNED Feb. 15, 1967			22c. PHYSICIAN'S NAME (Type) Norman H. Gemmill, M.D.		
22d. ADDRESS Stewartstown, Pa.											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF 2/16/1967		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE			23d. LOCATION (City, town or county) (State) BALTIMORE MARYLAND			
24. FUNERAL DIRECTOR'S SIGNATURE CHARLES E. KORTZ						ADDRESS TARRETTVILLE, MD			25a. REC'D BY REGISTRAR DATE FEB 17 1967		
						25b. REGISTRAR'S SIGNATURE Charles Judge					

MEDICAL CERTIFICATION

05840

05840

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
022251											
022247											
1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>HARFORD</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>					
c. LENGTH OF STAY IN 1b <u>12 hrs.</u>						d. STREET ADDRESS <u>406 Wyn Mar Ave.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harford Memorial Hospital</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Bertram Rorke Hendricks</u>						4. DATE OF DEATH <u>2</u> <u>8</u> <u>1967</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>20 July 1912</u>		9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Training Aids Super-</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>A.P.H.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William Hendricks</u>						14. MOTHER'S MAIDEN NAME <u>Ida Engerbretsen</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>WW-II</u>						16. SOCIAL SECURITY NO. <u>WW-II</u>		17. INFORMANT <u>Wife---Same as 2 C & D</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Anterior Myocardial Infarction</u> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Coronary thrombosis, extensive</u> DUE TO <u>Coronary arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes Mellitus</u>										INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>24 hrs.</u> <u>?</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>2/7</u> , 19 <u>67</u> , to <u>2/8</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>2/8</u> , 19 <u>67</u> , and that death occurred at <u>5:30 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Edward C. Lee, M.D.</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/8/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Lee, M.D.</u>						22d. ADDRESS <u>Harre de Grace, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>			23b. DATE THEREOF <u>11 Feb. 67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cresthaven Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Bedford Indiana</u>			
24. FUNERAL DIRECTOR <u>Walter Macomber Sr.</u>						ADDRESS <u>Aberdeen, Md.</u>		25a. REC'D BY REGISTRAR <u>FEB 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. [unclear]</u>	

ESSC

5250

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
02252						02248							
1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Harford</i>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford</i>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Stoppa</i>							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Harford Memorial Hospital</i>						d. STREET ADDRESS <i>416 Breshin Dr.</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <i>Joseph</i> Middle <i>Lee</i> Last <i>Hughes</i>			4. DATE OF DEATH Month <i>2</i> Day <i>11</i> Year <i>1967</i>			5. SEX <i>Male</i>			6. COLOR OR RACE <i>White</i>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <i>4 Feb. 1904</i>			9. AGE (In years last birthday) <i>63</i> yrs.			IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>		IF UNDER 24 HRS. Hours <i>10</i> Min. <i>0</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Chief, Trans. Br.</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Govt. EA.</i>				11. BIRTHPLACE (County & State, or foreign country) <i>Harford County, Md.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Morgan Hughes</i>						14. MOTHER'S MAIDEN NAME <i>Jessie Fulton</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>						16. SOCIAL SECURITY NO. <i>208-18-9115</i>			17. INFORMANT Address <i>Wife, Same as 2 C & D</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <i>4201</i> IMMEDIATE CAUSE (a) <i>myocardial infarction</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>4201</i> OUE TO (c) OUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (the hospital) attended the deceased from <i>2-11-67</i> , 19 to <i>2-11-67</i> , 19, that (I) <i>last</i> saw the deceased alive on <i>2-11-67</i> 19 and that death occurred at <i>7:35 PM</i> the causes and on the date stated above.													
22a. SIGNATURE <i>B.J. Plunkett Jr.</i>						M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <i>2-12-67</i>				
22c. PHYSICIAN'S NAME (Type) <i>B.J. Plunkett Jr. M.D.</i>						22d. ADDRESS <i>W. Bel Air Ave. Aberdeen, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>14 Feb. 67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Spesutia Cemetery</i>				23d. LOCATION (City, town or county) (State) <i>Perryman--Harford---Md.</i>			
24. FUNERAL DIRECTOR <i>Webster & Associates Inc.</i>						Tarring Funeral Home <i>Aberdeen, Maryland</i>		25a. REC'D BY REGISTRAR <i>DATE FEB 15 1967</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

24530

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02253

02249

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hwy 206 D.O.A.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rising Sun Rural</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. Hartford Memorial Hospital</u>				e. STREET ADDRESS <u>RD 2</u>			
3. NAME OF DECEASED (Type or print) First <u>Christina</u> Middle <u>Graham</u> Last <u>Hutton</u>				4. DATE OF DEATH Month <u>February</u> Day <u>7</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 10-1879</u>	9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN Home</u>		11. BIRTHPLACE (State or foreign country) <u>Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DAVID CALDEWELL</u>				14. MOTHER'S MAIDEN NAME <u>Helen Brown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>222-30-9303</u>		17. INFORMANT Address <u>Mrs Helen Dodds Rising Sun Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic CVD disease</u> <u>4221</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u> </u> <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Beidix nd</u> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>2-8-67</u>					
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		Address (Street, city, town, or county) <u> </u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2-11-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lower Brandywine</u>		23d. LOCATION (City, town or county) (State) <u>mendenhall PA.</u>	
24. FUNERAL DIRECTOR <u>Demon E. Mullen</u>		ADDRESS <u>Rising Sun Md.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Christina Graham Hutton

Aug 19 1878

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Herzowice Own Home Zealand N.S.A.

Helen Brown

David Caldwell

222-20-2333 Helen Dobbie King 2nd 1/2

NO

X

X

PA

Byrd 2-11-1967 Jones, Grandview Mendocino
Lester 2-11-1967 Jones, Grandview Mendocino
Lester 2-11-1967 Jones, Grandview Mendocino

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02254

CERTIFICATE OF DEATH

02250

1. PLACE OF DEATH a. COUNTY <u>HARford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYland</u> b. COUNTY <u>HARford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE de GRACE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock s</u> <u>12-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARford Memorial Hosp.</u>		d. STREET ADDRESS <u>Rock Ridge Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EMERY WEBSTER Johnson</u>		4. DATE OF DEATH Month Day Year <u>February 22 1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/27/1869</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Day labor</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Norrisville, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joshua Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Eliza Buchanan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-52-3899 T</u>	
17. INFORMANT Address <u>Miss Gladys Rice Rocks, Md. 21141</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Azotemia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chr. Cardiovascular - renal disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>14 days ?</u> <u>28 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-17</u> , 19 <u>67</u> , to <u>2-22</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2-22 1967</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Willard P. Hudson</u>		22b. DATE SIGNED <u>2-25-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Willard P. Hudson, M.D.</u>		22d. ADDRESS <u>2323 Rock Spring Road, Forest Hill, Md</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/25/1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fawn Zion A.M.E.</u>		23d. LOCATION (City, town or county) (State) <u>New Park, Penna.</u>	
24. FUNERAL DIRECTOR <u>Charles E. Kurtz</u>		25a. REC'D BY REGISTRAR <u>Jarrettsville, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>FEB 27 1967</u>	

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

02255

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02251

1. PLACE OF DEATH a. COUNTY <u>Hampson</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Hampson</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampson</u>		c. LENGTH OF STAY IN 1b <u>15 YRS.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Chapel Road RR#1 Box 216</u>		d. STREET ADDRESS <u>Chapel Road</u>	
3. NAME OF DECEASED (Type or print) <u>William Walker Jones</u>		4. DATE OF DEATH <u>February 6 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 24, 1919</u>
9. AGE (In years last birthday) <u>47</u> yrs.		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HARFORD METAL PRODUCTS CO. VA.</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GEORGE JONES</u>		14. MOTHER'S MAIDEN NAME <u>LAURA ANN GRALLEY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes give war or dates of service) <u>WORLD WAR II</u>		16. SOCIAL SECURITY NO. <u>214-16-3114</u>	
17. INFORMANT <u>MRS MYRTLE MAY PHILLIPS</u>		Address <u>HARFORD GRACE MD 21078 RR#1 Box 216</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cirrhosis Liver</u> <u>5810</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald P Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bx 1418, 22. DATE SIGNED <u>2-6-67</u>	
EXAMINER'S NAME (Type) <u>Gerald P Palmer MD</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>FEB. 8, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL CEM.</u>	23d. LOCATION (City or town) (County) (State) <u>HARFORD GRACE HARFORD MD</u>
24. FUNERAL DIRECTOR <u>R Madison Mitchell</u>		ADDRESS <u>Harford Grace, Md.</u>	
25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>FEB 10 1967</u>			

03521

03522

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
02256 CERTIFICATE OF DEATH 02252															
1. PLACE OF DEATH a. COUNTY Harford b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Aberdeen Proving Ground c. LENGTH OF STAY IN b 3 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kirk Army Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Aberdeen Proving Ground d. STREET ADDRESS 2824 Shandy Hall Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Andrew			First James			Middle LE VESQUE			Last LE VESQUE			4. DATE OF DEATH Month February Day 27 Year 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10 December 65			9. AGE (In years last birthday) 1 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -				10b. KIND OF BUSINESS OR INDUSTRY -				11. BIRTHPLACE (County & State, or foreign country) Fairfax, Virginia				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Victorian C. LE VESQUE						14. MOTHER'S MAIDEN NAME LA CAMERA, Jeanette									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. N/A				17. INFORMANT Father Address (Same as above)							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Meningitis, Bacterial 3403 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Congenital Heart Disease and Viremia															
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 84 Hours											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 24 Feb 67 xxx to 27 Feb 167 , that xx (we) last saw the deceased alive on 27 Feb 1967 , and that death occurred at 7:00am from the causes and on the date stated above.															
22a. SIGNATURE Thomas Fraher M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED 27 Feb 67						
22c. PHYSICIAN'S NAME (Type) THOMAS FRAHER, M.D.						22d. ADDRESS Kirk Army Hospital, Aberdeen PG, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 2 Mar. 67		23c. NAME OF CEMETERY OR CREMATORY Arlington National				23d. LOCATION (City, town or county) (State) Fort Meyer, Virginia					
24. FUNERAL DIRECTOR'S SIGNATURE Walter Macaulay Sr.						ADDRESS Tarring Funeral Home			25a. REC'D BY REGISTRAR DATE MAR 2 1967			25b. REGISTRAR'S SIGNATURE J Charles Judge			

MEDICAL CERTIFICATION

08330

08330

Married

Maryland

Hartford

American Proving Ground

3 days

American Proving Ground

Kirk Army Hospital

8004 Cherry Hill Road

Andrew

James

IN VERDUE

14 July 57

07

White

10 December 57

1

Victorian C. IN VERDUE

LA CANERA, Tennessee

No

N/A

father

(Same as above)

Meningioma, Inoperable

64 Hours

Constitutional Heart Disease and Vitis

13

27 Feb 57

04 Feb 57
07 Feb 57

27 Feb 57

07

NO

THOMAS FRANK, M.D.

Kirk Army Hospital, Aberdeen MD, Md.

Thomas Frank M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02257					02253				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <u>HARFORD</u> MARYLAND					a. STATE <u>MARYLAND</u> b. COUNTY <u>Cecil</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u>				
c. LENGTH OF STAY IN 1b <u>DOA</u>					d. STREET ADDRESS <u>52 MAIN</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HARford Memorial Hosp.</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>SAMUEL W. MITCHEM</u>					4. DATE OF DEATH <u>February 22 1967</u>				
5. SEX <u>MALE</u>					6. COLOR OR RACE <u>WHITE</u>				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>2-18-1920</u>				
9. AGE (In years last birthday) <u>47</u> yrs.					10. IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Taxi Driver</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Self-Employed</u>				
11. BIRTHPLACE (County & State, or foreign country) <u>W. Va.</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>SAMUEL A. MITCHEM</u>					14. MOTHER'S MAIDEN NAME <u>Filena Cadle</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give war or dates of service) <u>WW II</u>					16. SOCIAL SECURITY NO. <u>234-20-3347</u>				
17. INFORMANT <u>Pauline V. Mitchem</u>					Address <u>Port Deposit, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Failure</u> 241X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Acute Respiratory Infection</u> DUE TO (c) <u>Chronic Asthma</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>3 days</u> <u>10 yrs</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 19, 1967</u> , to <u>Feb 22, 1967</u> , that (I) (we) last saw the deceased alive on <u>Feb 22, 1967</u> , and that death occurred at <u>11:30</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Clarence I. Benson</u> M.D.					22b. DATE SIGNED <u>Feb. 23-67</u>				
22c. PHYSICIAN'S NAME (Type) <u>Clarence I. Benson M.D.</u>					22d. ADDRESS <u>Port Deposit, Md.</u>				
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>					23b. DATE THEREOF <u>2-24-1967</u>				
23c. NAME OF CEMETERY OR CREMATORY <u>Hopewell Cemetery</u>					23d. LOCATION (City, town or county) (State) <u>Port Deposit, Md.</u>				
24. FUNERAL DIRECTOR <u>see G. R. Johnson & Son, Perryville, Md.</u>					25a. REC'D BY REGISTRAR <u>Charles Judge</u>				
					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				
					DATE <u>FEB 28 1967</u>				

05827

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02258

02254

1. PLACE OF DEATH a. COUNTY <u>Harford</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u> c. LENGTH OF STAY IN 1b <u>Street</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Street</u>	
3. NAME OF DECEASED (Type or print) <u>Frank Montgomery</u> First Middle Last		4. DATE OF DEATH <u>February 22 1967</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 2, 1883</u> yrs. Months Days Hrs. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DAIRY</u>	
11. BIRTHPLACE (State or foreign country) <u>GATCHELVILLE, PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>BARNEY MONTGOMERY</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH SUTTON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>160-18-8235</u>	
17. INFORMANT <u>KENNETH MONTGOMERY, STREET, MD.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic CV Disease</u> 4221 DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		22. DATE SIGNED <u>2-22-67</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>FEB 25, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. NEBO</u>	23d. LOCATION (City, town or county) (State) <u>Delta, York, Pa.</u>
24. FUNERAL DIRECTOR <u>John H. Hawkins, Delta, Pa.</u> ADDRESS		25a. REC'D BY REGISTRAR <u>FEB 24 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

03250

03250

Barney Montomery Elizabeth Sutton

Farmer Dairy

Garfield, Pa.

U.S.A.

Aug. 13

M

190-12-1235 Kennedy

No

1
FOR STATE
HEALTH DEPT.
M
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1SME
5M 1/62

02259

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02255

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WHITEFORD (RURAL)		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WHITEFORD (RURAL) 12-1	
c. LENGTH OF STAY IN 1b 26 YRS		d. STREET ADDRESS WM. CRAIN FARM RD#1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WM. CRAIN FARM RD#1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES T. MOORE		4. DATE OF DEATH FEB 18 1967	
5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT 15, 1895 71 yrs.	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY 199-14-0339	
11. BIRTHPLACE (State or foreign country) DELTA, PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME GEORGE W. MOORE		14. MOTHER'S MAIDEN NAME EMMA MARSHALL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 199-14-0339	
17. INFORMANT BENJAMIN F. MOORE		Address 1056 E. POPULAR YORK, PA.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4341 CONGESTIVE HEART FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (b) 4341 (a), stating the underlying cause last. (c) 4341 DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) CA. PROSTATE - SCROTUM - PENIS (INSPECTION)		INTERVAL BETWEEN ONSET AND DEATH UNDETERMINE	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. NONE		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) NONE	
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Philip W. Heuman M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) PHILIP W. HEUMAN, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF FEB. 21, 1967	
22c. NAME OF CEMETERY OR CREMATORY SLATEVILLE		22d. LOCATION (City, town, or country) (State) DELTA, YORK CO., PA.	
23. FUNERAL DIRECTOR John H. Hawkins, DELTA, PA.		24. REC'D BY REGISTRAR FEB 21 1967	

05522

05522

John H. Johnson, Dallas, TX
Dallas, TX
Dallas, TX

John H. Johnson, Dallas, TX
Dallas, TX
Dallas, TX

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02260

CERTIFICATE OF DEATH

02256

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY CECIL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESAPEAKE CITY	
c. LENGTH OF STAY IN lb 3 WEEKS		d. STREET ADDRESS NONE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CITIZENS NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Margie Middle M. Last Payne		4. DATE OF DEATH Month 2 Day 2 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-26-1884
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 2 Days 2 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (County & State, or foreign country) CHESAPEAKE CITY, MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME NO INFO		14. MOTHER'S MAIDEN NAME NO INFO	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MARION T. REYNOLDS		Address CHESAPEAKE CITY, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Ca. DUE TO Ca. of the head of pancreas Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ca. of the head of pancreas (c) Ca. of the head of pancreas		INTERVAL BETWEEN ONSET AND DEATH 2 months 5 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) A.S.C.V.D. + Senility		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 1, 1966 to Feb. 2nd, 1967 , that (I) (we) last saw the deceased alive on Feb. 2nd 1967 , and that death occurred at 5:42 P.M. from causes on and on the date stated above.			
22a. SIGNATURE Edward C. Lee, M.D.		22b. DATE SIGNED 2/2/67	
22c. PHYSICIAN'S NAME (Type) Edward C. Lee, M.D.		22d. ADDRESS Havre de Grace, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2-5-67	
23c. NAME OF CEMETERY OR CREMATORY BETH EL		23d. LOCATION (City or Town) (County) (State) CHESAPEAKE CITY, MD.	
24. FUNERAL DIRECTOR PIPPIN FUNERAL HOME		25a. REC'D BY REGISTRAR 1967	
25b. REGISTRAR'S SIGNATURE James J. Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03328

03328

Form with multiple sections and fields, including checkboxes and text areas. The form is heavily obscured by noise and artifacts, making the content illegible. Two black circular marks are visible on the right side of the page.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
02261 CERTIFICATE OF DEATH 02257

1. PLACE OF DEATH a. COUNTY <i>Hartford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Hartford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Havre de Grace</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Havre de Grace</i>	
c. LENGTH OF STAY IN 1b <i>9 days</i>		d. STREET ADDRESS <i>509 Franklin St.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Hartford Memorial Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>William</i> Middle <i>Curtis</i> Last <i>Perry</i>		4. DATE OF DEATH Month <i>February</i> Day <i>10</i> Year <i>1967</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/23/1906</i>
9. AGE (In years last birthday) <i>60</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Municipal Utilities</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Chesapeake, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles Perry</i>		14. MOTHER'S MAIDEN NAME <i>Annie Johnson</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <i>Unk.</i>	
17. INFORMANT <i>Myrtle Patis Perry</i> Address <i>509 Franklin St., Havre de Grace Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest following ventricular fibrillation</i> 410X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Rheumatic mitral & aortic valvulitis</i> DUE TO (c) <i>50 yrs</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Feb. 2</i> , 19 <i>67</i> , to <i>Feb. 10</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>Feb. 10</i> , 19 <i>67</i> , and that death occurred at <i>7:30</i> AM, from the causes and on the date stated above.			
22a. SIGNATURE <i>Richard J. Colfax</i>		22b. DATE SIGNED <i>Feb 10, 1967</i>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>2/13/67</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Angel Hill Cem.</i>		23d. LOCATION (City, town or county) (State) <i>Havre de Grace Md</i>	
24. FUNERAL DIRECTOR <i>Connington & Son</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
25b. REGISTRAR'S SIGNATURE		DATE <i>FEB 14 1967</i>	

03530

03530

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

02262

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02258

1. PLACE OF DEATH o. COUNTY <u>Harrison</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Harrison</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill</u>	c. LENGTH OF STAY in 1b <u>40 Yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Forest Hill</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>S</u> Plummer Last <u>Plummer</u>		4. DATE OF DEATH Month <u>February</u> Day <u>13</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-14-91</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Furniture Store Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) yrs. <u>75</u>
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Wilson M. Plummer</u>		14. MOTHER'S MAIDEN NAME <u>Valeria Peake</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes WW 1</u>		16. SOCIAL SECURITY NO. <u>218-32-1517A</u>	
17. INFORMANT <u>Mrs. Grace Plummer, Forest Hill, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> Bel Air	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>5-14-67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/16/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fawn Grove Meth. Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Fawn Grove, York Co., Pa.</u>	
24. FUNERAL DIRECTOR <u>Kenneth W. Whetstone</u>		25a. REC'D BY REGISTRAR <u>Stewartstown, Pa.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>FEB 16 1967</u>	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02263

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02259

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u>		c. LENGTH OF STAY IN 1b <u>12-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2109 Nuttal Ave. Box 1025</u>		d. STREET ADDRESS <u>2109 Nuttal Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Arthur</u> Middle <u>Harrison</u> Last <u>Price</u>		4. DATE OF DEATH Month <u>2</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 16 - 1935</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unemployed</u>	9. AGE (In years last birthday) yrs. <u>31</u>
11. FATHER'S NAME <u>Clifford H. Price</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. MOTHER'S MAIDEN NAME <u>Ruth Homer (Gecard)</u>		14. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Gorothy Party</u>		Address <u>66 Nixon Ave Aberdeen</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Tumor Brain, Malignant</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Lorneel C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> 2-21-67	
EXAMINER'S NAME (Type) <u>Gerald C Palmer, MD</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22. DATE SIGNED <u>2-21-67</u>	
Address (Street, city, town, or county) <u>Belt Air, Md</u>			
23a. BURIAL, CREMATION, or other disposal <u>Burial</u>	23b. DATE THEREOF <u>24 Feb. 67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Harford Memorial Gardens, Aberdeen Maryland</u>	23d. LOCATION (City or town) (County) (State)
24. FUNERAL DIRECTOR <u>Walter W. W. W. W.</u>		25a. REC'D BY REGISTRAR <u>FEB 24 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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Harford

Bedford

2107 Nuttal Ave Apt 1052

Harlem

Harlem

Male white

Unemployed

Clifford A Price

Age

None

Tumor Brain, Malignant

Spontaneous

Left Arm (Painful)

Unemployed

Age - 1952 31

Price

2107 Nuttal Ave

Bedford

Harford

Harford

James E. Brown

1001 6 1010 11

5-21-67

x

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Harlem

1001 6 1010 11

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Harrison</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u> c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Harrison</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Joppa</u> d. STREET ADDRESS <u>109 DONCASTER RD.</u>	
3. NAME OF DECEASED (Type or print) <u>Kyle Ann Purcell</u> First Middle Last 4. DATE OF DEATH <u>February 12</u> 19 <u>67</u> Month Day Year		6. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 28, 1966</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>2</u> yrs. IF UNDER 1 YEAR: Months <u>2</u> Days <u>12</u> Hours <u>19</u> Min.
11. BIRTHPLACE (State or foreign country) <u>Maryland City</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edgar L. Purcell</u>		14. MOTHER'S MAIDEN NAME <u>MARY CAROL KARCHER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Edgar L. Purcell</u>		Address <u>(SAME)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>7593 Congenital Abnormality</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>DUE TO</u> (c) <u>DUE TO</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerard C Palmer</u>		M.O. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerard C Palmer</u>		Address (Street, city, town, or county) <u>2-13-67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>2/14/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>	23d. LOCATION (City, town or county) (State) <u>BALTO. MD.</u>
24. FUNERAL DIRECTOR <u>LEONARD J. RUCK Inc. BALTO. MD. 21214</u>		25a. REC'D BY REGISTRAR <u>FEB 14 1967</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02265					02261				
1. PLACE OF DEATH a. COUNTY Harford MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Harford				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Pal Air, R # 1			c. LENGTH OF STAY IN 1b Since 8/29/59		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 110 S/ Washington St/ Havre De Grace, Md.				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Convalescent Home					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Georgia Middle Rimney Last Rimney			4. DATE OF DEATH Month Feb. Day 15, Year 1967						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 28, 1885		9. AGE (In years last birthday) 81 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Samuel Rimney					14. MOTHER'S MAIDEN NAME Elizabeth Horn				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 4201		17. INFORMANT Wm. Rimney Address 403 Donaldson St., Highland Park, D.C.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chr. Arteriosclerotic cardiovascular disease DUE TO (c) with hypertension								INTERVAL BETWEEN ONSET AND DEATH 3 days ??	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from April 29, 1959 , to Feb. 15, 1967 , that (I) (we) last saw the deceased alive on Feb. 14, 1967 , and that death occurred at 6:30 AM , from the causes and on the date stated above.									
22a. SIGNATURE Willard P. Hudson				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2-15-67			
22c. PHYSICIAN'S NAME (Type) Willard P. Hudson, M.D.				22d. ADDRESS Forest Hill, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 2/18/67		23c. NAME OF CEMETERY OR CREMATORY Angel Hill		23d. LOCATION (City, town, or county) (State) Havre De Grace Md.			
24. FUNERAL DIRECTOR William P. Hudson				ADDRESS Havre De Grace Md.		25a. REC'D BY REGISTRAR Feb 21 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR AIS (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02266						02262					
1. PLACE OF DEATH a. COUNTY Harford b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Aberdeen PG c. LENGTH OF STAY IN 1b 1 Day d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kirk Army Hospital						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood Arsenal d. STREET ADDRESS 6667-D Reider Ct. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Haskel			First Middle Last Schiff			4. DATE OF DEATH February 13 1967			Month Day Year		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 13 October 1936		9. AGE (In years last birthday) 30 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician				10b. KIND OF BUSINESS OR INDUSTRY US Army		11. BIRTHPLACE (County & State, or foreign country) Kings Co., New York			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME William Schiff						14. MOTHER'S MAIDEN NAME Jean Peckman					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 3 Mar 66-13 Feb 67 070-28-2076		17. INFORMANT Military Personnel Records Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe Contusion and Laceration of Brain DUE TO (b) Skull Fracture, Severe Facial Fracture and Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) Cervical Dislocation										INTERVAL BETWEEN ONSET AND DEATH 2 Hrs, 35 Min 2 Hrs, 35 Min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Automobile Accident											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of an auto involved in an accident approx. 1030 hours Rte 7 and Route 40, Aberdeen, Maryland											
20c. TIME OF INJURY Month, Day, Year Hour e.m. 1030 xx Feb 13 19 67				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) Aberdeen (County) Harford (State) Md.			
21. I certify that XX (this hospital) attended the deceased from 13 Feb 19 67 to 13 Feb 19 67 , that XX (we) last saw the deceased alive on 13 Feb 19 67 , and that death occurred at 1:05 PM from the causes and on the date stated above.											
22a. SIGNATURE Leopoldo E Molano M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 13 Feb 67			
22c. PHYSICIAN'S NAME (Type) LEOPOLDO MOLANO, Lt Col, MC						22d. ADDRESS Kirk Army Hospital, Aberdeen PG, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 2/14/67		23c. NAME OF CEMETERY OR CREMATORY Beth David Cemetery			23d. LOCATION (City, town or county) (State) Elmont, New York			
24. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son						ADDRESS Perryville Md.		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE FEB 21 1967											

Bernice E. Mc

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Hartford

Hartford

Hartford

1 day

Anderson

Anderson

Kirk Army Hospital

0007-D Hospital Co.

Hospital

Hospital

Hospital

Hospital

White

White

13 October 1950

William Schell

US Army

Kings Co., New York

USA

William Schell

John P. Schell

31-6-13-50 000-08-005

Military Personnel Records

Severe Contusion and Laceration of Head

Skull fracture, Severe facial lacerations and

Cervical Dislocation

Automobile Accident

Driver of an auto involved in an accident near 1030 hours
Mrs. J. and Mrs. M. Anderson, Hartford

1030 hr Feb 13 57

Street

Anderson, Hartford, Conn.

XX

13 Feb 57

1:02 PM

13 Feb 57

1030 HOURS FEB 13 57

Kirk Army Hospital, Anderson, Conn.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

02267

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

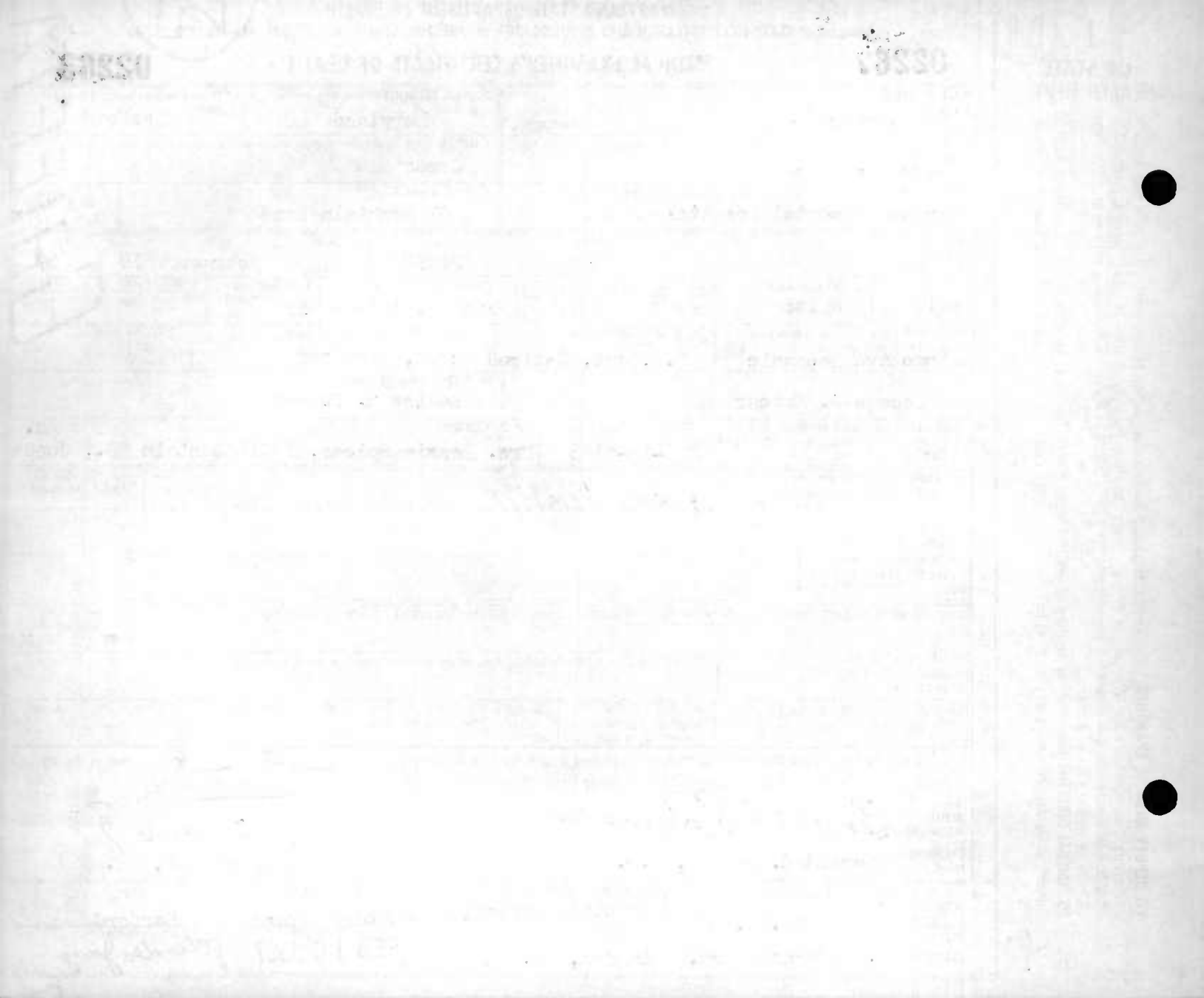
02263

1. PLACE OF DEATH o. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Joppa	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Harford Memorial Hospital - DOA		d. STREET ADDRESS 1501 Mountain Road	
3. NAME OF DECEASED (Type or print) First VERNON Middle BROWN Last SPICER		4. DATE OF DEATH Month February Day 14 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 9, 1899
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Automotive Mechanic		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt. Retired	9. AGE (In years last birthday) yrs. 67
11. BIRTHPLACE (State or foreign country) Joppa, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George B. Spicer		14. MOTHER'S MAIDEN NAME Louise M. Turner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-16-8193	
17. INFORMANT Mrs. Bessie Spicer		Address 1501 Mountain Rd., Joppa, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) 1814/4/1971 Coronary occlusion DUE TO (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE Gerald C. Palmer M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Gerald C. Palmer, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 2-14-67	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) Bel Air, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Feb. 17, 1967	23c. NAME OF CEMETERY OR CREMATORY Mountain Christian Cemetery Joppa	23d. LOCATION (City or Town) (County) (State) Harford Md
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md. 21009		25a. REC'D BY REGISTRAR FEB 16 1967	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

10550

10550



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

02268

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02264

1. PLACE OF DEATH o. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hartford</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dox Hartford Memorial Hosp.</u>		d. STREET ADDRESS <u>1300 Juniper St</u>	
3. NAME OF DECEASED (Type or print) <u>Luther B. Wardell</u>		4. DATE OF DEATH <u>February 15 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-7-1902</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mechanic</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Grant Wardell</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Preston</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Audrey Riale, Coloma, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, md</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-10-1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Asbury Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Port Deposit, md</u>	
24. FUNERAL DIRECTOR <u>Lee A. Patterson & Son, Perryville, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		FEB 21 1967	

13880

STATE OF NEW YORK

13880

IN SENATE

JANUARY 13, 1904

02269

CERTIFICATE OF DEATH

02265

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Aberdeen		c. LENGTH OF STAY IN 1b 12-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route #1		d. STREET ADDRESS Route #1, Box 81	
3. NAME OF DECEASED (Type or print) First MARY Middle JANE Last WEST		4. DATE OF DEATH Month February Day 19 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 27 Oct. 1887
9. AGE (In years last birthday) yrs. 79		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Ashe County, N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME D.G. Pasley		14. MOTHER'S MAIDEN NAME Nancy Bell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. -- -- --	
17. INFORMANT Husband		Address Same as 2 C & D	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic CV Disease 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1-1 , 19 66 , to 2-19 , 19 67 , that (I) (we) last saw the deceased alive on 2-17 , 19 67 , and that death occurred at 9:40 A.M. from causes and on the date stated above.			
22a. SIGNATURE Gerald C. Palmer		22b. DATE SIGNED 2-20-67	
22c. PHYSICIAN'S NAME (Type) Gerald C. Palmer, M.D.		22d. ADDRESS Bel Air, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF 21 Feb. 67	23c. NAME OF CEMETERY OR CREMATORY Pleasant Home Cemetery	23d. LOCATION (City or Town) (County) (State) Grassy Creek, N.C.
24. FUNERAL DIRECTOR Helton Macaulay Jr.		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE FEB 23 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

02270

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02266

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u>		c. LENGTH OF STAY IN 1b <u>3 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hale's Trailer Court</u>		d. STREET ADDRESS <u>Hale's Trailer Court</u>	
3. NAME OF DECEASED (Type or print) <u>Herbert Randolph Wilson</u>		4. DATE OF DEATH <u>February 10 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 22, 1963</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	9. AGE (In years last birthday) <u>3</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Harford Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John A. Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Jeannine Wayne</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>John A. Wilson, Edgewood, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia due to CO</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Trailer burned</u>	
20c. TIME OF INJURY Month, Day, Year <u>1230 p.m. 2-10-1967</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Edgewood Harford Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> 2-10-67	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Bela</u> Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>Feb. 11, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>McKenzie F.H.</u>
24. FUNERAL DIRECTOR <u>Howard K. McComas & Son, Abingdon, Md. 21009</u>		23d. LOCATION (City or Town) (County) (State) <u>Whiteville, Columbus N.C.</u>	
25a. REC'D BY REGISTRAR <u>FEB 14 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

03880

03880

UNITED STATES DEPARTMENT OF AGRICULTURE

[Faint, mostly illegible handwritten text, possibly a memorandum or report, covering the majority of the page.]

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02271

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02267

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u>		c. LENGTH OF STAY IN lb <u>4 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hales Trailer Court</u>		d. STREET ADDRESS <u>Hales Trailer Court</u>	
3. NAME OF DECEASED (Type or print) <u>Stephen Wayne Wilson</u>		4. DATE OF DEATH Month <u>February</u> Day <u>10</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 27, 1962</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	9. AGE (In years last birthday) <u>4</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Columbus Co., N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John A. Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Jeannine Wayne</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>John A. Wilson, Edgewood, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia due to CO</u> <u>9160</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Trailer Burned</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>12:00</u> p.m. <u>2-10-67</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Edgewood Ha Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>2-10-67</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer MD</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Bel Air, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>Feb. 11, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>McKenzie F.H.</u>		23d. LOCATION (City or Town) (County) (State) <u>Whiteville, Columbus N.C.</u>	
24. FUNERAL DIRECTOR <u>Howard K. McComas & Son, Abingdon, Md. 21009</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 14 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02272

CERTIFICATE OF DEATH

02268

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace		c. LENGTH OF STAY IN lb Darlington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Citizens Nursing Home		d. STREET ADDRESS Route #1, Box 145	
3. NAME OF DECEASED (Type or print) First Virginia Middle Jones Last Wilson		4. DATE OF DEATH Month February Day 25 Year 1967	
5. SEX Female	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 15 Nov. 1879
9. AGE (In years last birthday) yrs. 87		10. IF UNDER 1 YEAR Months 25 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Harford County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hugh A. Jones		14. MOTHER'S MAIDEN NAME Cornelia Touchstone	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Cornelia W. Kirk, Darlington, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia Rt lung 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Generalized arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 24 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 12, 1960 , to Feb 25, 1967 that (I) (we) last saw the deceased alive on Feb 25, 1967 , and that death occurred at 8: PM from causes and on the date stated above.			
22a. SIGNATURE Dudley Phillips		22b. DATE SIGNED 2/25/67	
22c. PHYSICIAN'S NAME (Type) Dudley Phillips, M.D.		22d. ADDRESS Darlington, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 28 Feb. 67	
23c. NAME OF CEMETERY OR CREMATORY Darlington Cemetery		23d. LOCATION (City or Town) (County) (State) Darlington, Har. Md.	
24. FUNERAL DIRECTOR Webster Macomber Jr		25. REC'D BY REGISTRAR Aberdeen, Md.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE MAR 1 1967	

05258

RECEIVED

05258

TO THE HONORABLE SECRETARY OF THE ARMY

WASHINGTON, D. C.

DEAR SIR:

I have the honor to acknowledge the receipt of your letter of the 10th inst.

and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully, your obedient servant,

Wm. A. Jones

Colonel, U. S. Army

Very truly yours,

Wm. A. Jones

Colonel, U. S. Army

Enclosed for you are two copies of a report of the Committee on the subject of the proposed change in the organization of the Department of the Army.

I am, Sir, very respectfully, your obedient servant,

Wm. A. Jones

Colonel, U. S. Army

Very truly yours,

Wm. A. Jones

Colonel, U. S. Army